Gynecology Specialists of Philadelphia

39th and Market Street, Penn Presbyterian Medical Center, MOB 340
Philadelphia, PA 19104
P: 215-662-9775 * F: 215-243-4668

823 South 9th Street, 1st Floor
Philadelphia, PA 19147
P: 267-239-2725 * F: 267-239-2728

Last Name_____ First Name_____MI___

SS#_____ DOB_____

E-Mail address _____

Address_____

City _____State_____ Zip _____

Best Phone# _____ (home/ work/ cell)

Alternate # _____ (home/ work/ cell)

Race_____ Ethnicity (Hispanic/non-Hispanic)_____DECLINE

Preferred Language _____ Marital Status _____

Preferred Pronoun _____ Gender _____

Employer_____ Occupation_____

Pharmacy Name _____ Pharmacy Phone # _____

Emergency Contact

Name_____ Phone #_____Relationship_____

Address _____

Insurance Information: Please provide a copy of your insurance card

Insurance Subscriber (if not self):_____ Subscriber DOB: _____
Subscriber
Address_____Relationsip_____

May we speak to a friend/family member about your health/results over the phone? If so list their name (s) here; _____
_____

Referral Information

Referred BY (circle) Doctor _____ Website Insurance PENN Referral Line

Primary Care/ Family Doctor_____ Phone #_____

*I hereby authorize the release of medical information necessary for the processing of my medical/ laboratory claims. I authorize payment to Gynecology Specialists of Philadelphia LLC. I take full responsibility for payment for all services rendered. A photocopy of this authorization is as valid as the original.
* I have received a copy of GSP Privacy & Office Policies. I have read and agree to comply with these policies.

Patient Signature _____Date _____

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Name_____ DOB_____

Medical History: Have you had the following?

___ High Blood Pressure	___ Heart Attack	___ Depression
___ High Cholesterol	___ Stroke	___ Anxiety
___ Diabetes	___ Blood Clot (lung)	___ Seizures
___Anemia	___ Blood Clot (leg)	___ Migraines
___ Hyperthyroidism	___ Bowel Obstruction	___ Kidney Failure
___ Hypothyroidism	___ Crohn's Disease	___ Kidney Stones
___ Breast Cancer	___ Ulcerative Colitis	___ Sarcoidosis
___ Cervical Cancer	___ Irritable Bowel (IBS)	___ Sickle Cell Disease
___ Ovarian Cancer	___ GERD (Acid Reflux)	___ Lupus
___ Uterine Cancer	___ Hepatitis B	___ Rheumatoid Arthritis
____ Asthma	___ Hepatitis C	___ Gallstones
___ Sjogren 's syndrome	___ Emphysema	___ Anorexia/ Bulimia

___ Other _____

Surgical History: Please list name and date of procedure if possible

_____

_____

Medications:

Name	Dose	Times per day

Allergies: _____ **No Known / Unknown**

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Name_____ DOB_____

Chief Complaint/ Reason for Visit:

_____

Gynecologic History:
First day of your last period_____

Date of your last ANNUAL/PAP exam _____ Any abnormal pap tests? Yes/ No

Date of last mammogram _____Any abnormal mammograms? Yes/ No

Have you had 3 Gardasil Vaccines? Yes/ No

List any GYN problems you have or had in the past (i.e. Fibroids, endometriosis, PID, cysts, ETC)

_____
_____
_____

Contraceptive History:

What are you using for birth control? Circle all that apply

None tubal ligation vasectomy pills Nuva Ring condoms IUD Depo

Any problems with contraception now or in the past? _____

Obstetrical History:

How many pregnancies have you had? _____
How many children delivered? _____ Vaginal or C-Section
Miscarriages _____ Abortions_____ Ectopic or Tubal Pregnancies _____

Family History:

Has anyone in your family had cancer? Yes/ No

Please list who has or had cancer, maternal or paternal, the type of cancer, and the age of diagnosis:

_____
_____

Social History:

Do you smoke? **Yes/ No** Drink alcohol? **Yes/ No** Use other drugs? **Yes/ No** Caffeine? **Yes/ No**

Are you sexually active? **Yes/ No** If yes, with **men** **women** **both**

Have you ever had a sexually transmitted disease (STD)? **Yes/ No**
If yes, what did you have? _____ Were you treated? **Yes/ No**

Any history of abuse? Physical? **Yes/No** Emotional? **Yes/No** Sexual? **Yes/No** Verbal? **Yes/No**

Any other health history we should be aware of? _____

_____

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OFFICE POLICIES

There are many practices you could have chosen for your gynecologic care. We would like to take the time to thank you for choosing Gynecology Specialists of Philadelphia. It is our desire to provide personalized, compassionate, top-notch care to all of our patients and understand it is important that play an active role in their health care. To that end, we believe our patients should have a full understanding of our office policies, expectations and procedures so as to optimize your experience with us. Please take time to read the information outlined below.

Our office accepts routine phone calls from 8:30 am – 4:15 pm Monday-Thursday and 8:30 am – 2:30 pm on Friday. Please make non-emergency calls during these hours so that we have access to your medical records and can better serve you.

INSURANCE: There are numerous insurance plans available therefore, it's impossible for our staff to know the covered benefits of each plan. It is YOUR responsibility to know and understand the policies and benefits of your plan including referrals, authorizations, co-payments, deductibles, covered hospitals, labs and x-ray (radiology) facilities.

APPOINTMENTS: We will make every effort to schedule your appointment in an appropriate time frame. **YEARLY WELL-WOMAN EXAMS** will be scheduled within **ONE TO THREE MONTHS** of calling. Scheduling these routine exams in that time frame is important in order to allow patients with urgent medical needs to be seen in a shorter time frame. If you are due for your well-woman exam and have an urgent problem, we will make **two** appointments for you – an **earlier** appointment for the **problem** and a **later** appointment for the **well-woman exam.**

Due to the nature of our practice, we occasionally need to reschedule an appointment you have made and appreciate your understanding should this be the case. We ask that you give 24 hours notice if you need to reschedule.

FIRST TIME OFFICE VISITS: Please arrive 15 minutes early for your appointment to allow enough time to complete your registration forms. Please bring a list of all current medications. If this is a consult, please be sure your referral has been sent (if required) and bring any appropriate reports and lab results.

LABORATORY: All lab tests performed in the office (pap smears, cultures, biopsies) are processed and billed to you by outside laboratories. We do not draw blood at our office. We will provide you a lab slip and bloodwork should be done at Quest or LabCorp according to your insurance coverage.

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TEST RESULTS: Some test results may be reviewed with you over the phone. Others may require a follow up appointment to discuss. **This decision is made at the discretion of your provider.**

> ****Most results take approximately 2-3 weeks to return to our office – this includes pap smears, cultures, blood work, biopsies and most radiology studies including routine mammograms. If you have not heard from our office within that time frame, please contact the office.**

TELEPHONE: One of our providers is on-call every evening, including weekends, for **emergencies.** The answering service takes all calls after hours. Routine prescriptions (ie: birth control), appointment scheduling/confirmation/cancellations and reviewing of test results will not be handled after hours.

We cannot treat patients over the telephone. If you feel you have a true medical emergency, please call 911 or go to the nearest emergency room.

PRESCRIPTION REFILLS: If you contact our office for a prescription refill, please have the medication name and your pharmacy phone number ready. There is a 24 hour turnaround for refill requests. If you need a prescription refilled before the weekend, please call ahead to allow time to process your request. **We cannot refill medications after hours or on weekends.**

OFFICE VISIT PUNCTUALITY: We value all of our patients and we appreciate that your time is precious. Our goal is that we are as punctual as possible and see you for your appointment in a timely manner. However, circumstances arise **on a daily basis** which compromise our ability to be punctual. It is our hope that you will be as understanding as possible with the demands on our staff, especially due to surgical emergencies which require the providers to attend to patients in the hospital or emergency room throughout the day. Our intention is to provide all of our patients with the utmost in medical care. We hope that you will be understanding of these dynamics as they are an inherent part of any gynecology practice which affect our punctuality.

Thank you!

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I HAVE READ AND AGREE TO COMPLY WITH GYNECOLOGY SPECIALISTS OF PHILADELPHIA OFFICE POLICIES.

_____
Printed Name of Patient

_____ _____
Signature of Patient Date

The undersigned certifies that she has received a copy of *Notice of Privacy Practices (NPP)* and is the patient, or is the patient's personal representative,

_____ _____
Printed Name of Patient or Personal Representative Relationship

_____ _____
Signature of Patient Date

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NO SHOW/MISSED APPOINTMENT POLICY

We at Gynecology Specialists of Philadelphia, understand that sometimes you need to cancel or reschedule your appointment and that there are emergencies. If you are unable to keep your appointment, please call us as soon as possible (with at least 24-hour notice). You can cancel/reschedule appointments by calling us at (215) 662 – 9775.

To ensure that each patient is given the proper amount of time allotted for their visit and to provide the highest quality care, it is very important for each scheduled patient to attend their visit on time. As a courtesy, an appointment reminder call is attempted prior to your scheduled appointment. However is the responsibility of the patient to arrive for their appointment on time.

PLEASE REVIEW THE FOLLOWING POLICY

1. Please cancel your appointment with at least 24 hours' notice so your appointment time can be offered to other patients.
2. If less that 24-hour cancellation given, this will be documented as a "no-show" appointment.
3. If you do not show up to your scheduled appointment, this will be documented as a "no-show" appointment.
4. You will receive an automated message notifying you of your missed appointment.
5. There is a $15 no show fee for each appointment missed.
6. After x3 or more "no-show/missed" appointments, dismissal from our practice may be considered.

I have read and understand Gynecology Specialists of Philadelphia's No-Show/Missed Appointment Policy and understand my responsibility to plan appointments accordingly and notify Gynecology Specialists of Philadelphia appropriately if I have difficulty keeping my scheduled appointment.

_____ _____

Patient Name Date of Birth

_____ _____

Patient Signature Date

CREDIT CARD AUTHORIZATION

Credit Card Information				
Card Type:	☐ MasterCard	☐ VISA	☐ Discover	☐ AMEX
	☐ Other _____			
Cardholder Name (as shown on card): _____				
Card Number: _____				
Expiration Date (mm/yy): _____			CVV/CVDC: _____	
Cardholder ZIP Code (from credit card billing address): _____				

I, _____, authorize Gynecology Specialists of Philadelphia to charge my credit card above for the agreed amount. I understand that my information will be saved on file for future transactions on my account.

_____ _____

Patient Signature Date

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AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

Authorization for Use/Disclosure of Information: I_____,

DOB _____ voluntarily consent to authorize my health care provider (complete provider's name, telephone # and fax # below)

_____to use or disclose my health information during the term of this authorization to the recipient(s) that I have identified below.

Recipient: I authorize my health care information to be released to the following recipient(s):

Name: _____

Address: _____

Purpose: I authorize the release of my health information for the following specific purpose:

_____.

(Note: "at the request of the patient" is sufficient if the patient is initiating this Authorization)

Information to be disclosed: I authorize the release of the following health information: (check the applicable box below)

- ☐ All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me.[1]
- ☐ Only the following records or types of health information:

  _____.

Term: I understand that this Authorization will remain in effect:

- ☐ From the date of this Authorization until the _____ day of _____, 20___.
- ☐ Until the Provider fulfills this request.
- ☐ Until the following event occurs:_____

Redisclosure: **I understand that my health care provider cannot guarantee that the recipient will not disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.**

_____ _____

SIGNATURE OF PATIENT DATE

[1] **NOTE: This Authorization does not extend to HIV test results, outpatient psychotherapy notes, drug or alcohol treatment records that are protected by federal law, or mental health records that are protected by the Lanterman-Petris-Short Act.**